MDR Tracking Number: M5-04-1847-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on February 23, 2004.

The IRO reviewed the Chronic Pain Management program rendered from 04/07/03 through 05/27/03 that was denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On May 20, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Code 97799-CP for dates of service 04/15/03, 04/16/03, 04/25/03, 04/28/03 through 05/08/03. Review of the requestor's and respondent's documentation revealed that neither party submitted copies of EOB's, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed service will be reviewed according to the 1996 Medical Fee Guideline. Per the 1996 Medical Fee Guideline CPT descriptor, this code is a DOP item. In accordance with the Texas Labor Code 413.011 and Commission Rule 133.1(a)(8) the requestor did not submit relevant information (i.e. redacted EOB's for same or similar services) supporting the amount billed is the health care providers usual and customary charge. Reimbursement is not recommended.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision is hereby issued this 30th day, September 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division
MF/mf

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 04/07/03 through 05/27/03 in this dispute.

This Order is hereby issued this 30th day of September 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division
RL/mf

Enclosure: IRO Decision

May 7, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1847-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ------ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in anesthesiology and is familiar with the condition and treatment options at issue in this appeal. The ------ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a male who sustained a work related injury on ------. The patient reported that while at work he injured his low back while attempting to stop boxes from falling. A peer review dated 2/28/03 indicated that the patient was evaluated at a hospital where he was diagnosed with low back strain on 4/2/02 and again on 4/6/02 with the same diagnosis. It noted that on 4/8/02 the patient was evaluated and given the diagnoses of contusion to lumbosacral area and strain and paravertebral spasm. It further noted that the patient began physical therapy and prescribed oral medications. Cervical x-rays dated 4/15/02 was reported to show disc space narrowing with mild spondylosis at C5-6, a thoracic x-ray dated 4/15/02 was reported to be negative, and lumbar x-rays dated 4/15/02 were reported to have shown asymmetrical transitional vertebra at L5 with hypertrophy and psuedoarthrosis fo the left transverse process, right convex thoracolumbar functional scoliosis, disc space narrowing and anterolateral spondylosis at L2-3, L3-4, and L4-5. It indicated that the patient then underwent an MRI of the cervical and lumbar spine on 4/30/02. It further indicated that the patient underwent EMG testing, peer reviews, an orthopedic evaluation, designated doctor review, an FCE, and continued treatment of oral medications and physical therapy.

Requested Services

Unlisted phys med svs/prc, psych svcs pharmacologic from 4/7/03 through 5/27/03.

Documents and/or information used by the review to reach a decision:

Documents Submitted by Requestor:

1. Peer review 2/28/03 Philip Osborne, MD
2. Comprehensive Pain Reduction Center notes(no dates)
3. Brando Chiropractic 4/11/02-4/14/03
4. Dr. Doctor 9/27/02
5. Dr. Cupic 7/29/02-8/21/02
6. FCE 1/20/03
7. Dr. Bakht 3/14/03-5/27/03
8. MRI reports 4/30/02

Documents Submitted by Respondent:

1. Required medical evaluation 2/28/03, 4/24/03
2. Peer Review Dr. Osborne 4/24/03
3. Directions in Prescriptive Chronic Pain Management (computerized print out)
4. Hospital admit notes 4/2/01
5. Dr. Scott Bischoff 4/8/02-4/10/02

6. Brando Chiropractic 4/11/02-2/18/03
7. X-Ray reports 4/15/02
8. MRI reports 4/30/02
9. EMG/NCV 4/23/02
10. Peer review 5/25/02 Dr. O'Kelley, D.C.
11. Investigation report 6/17/02
12. Dr. Doctor 11/5/02-1/8/03
13. FCE 1/20/03
14. Comprehensive Pain Reduction Center 3/14/03-5/27/03

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ------ physician reviewer noted that this case concerns a male who sustained a work related injury to his low back on ------. The ------ physician reviewer indicated that the patient has undergone evaluations, including an MRI of the cervical and lumbar spine, orthopedic evaluations, chiropractic evaluations, designated doctor reviews and pain management. The ------ physician reviewer noted that the treatment for this patient's condition has included physical therapy, chiropractic therapy, medical therapy, interventional therapy with epidural steroid injections and facet blocks. The ------ physician reviewer explained that the patient has a work related chronic pain condition. The ------ physician reviewer indicated that the diagnoses for this patient include cervical strain, cervical disc disease C5-6, thoracic strain, herniated disc L2-3 and L3-4, bulging discs at L4-5 and L5-S1, and bilateral L5 radiculopathy. The ------ physician reviewer explained that the patient has tried and failed conservative and interventional therapies. The ------ physician reviewer also explained that the patient is not considered a surgical candidate. The ------ physician reviewer further explained that a chronic pain management program was medically necessary to address in a comprehensive manner, both the enrollee's pain behavior and depressive symptoms that make up his chronic pain syndrome. Therefore, the ------ physician consultant concluded that the unlisted phys med svs/prc, psych svcs pharmacologic from 4/7/03 through 5/27/03 were medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department